California's Health

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RELIEF HOME TO REHABILITATION CENTER

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Converting a county relief home to a comprehensive rehabilitation center is indicative of a giant step forward in a community's concept of enlightened social responsibility. If we can accept that the things we do about human problems, rather than what we say should be done about them, are an index of the level of civilization which we have reached, then the actual conversion of an ancient and discredited institution into enlightened and constructive usage may be regarded as a significant landmark in a community's efforts to deal more effectively and helpfully with the solution of human problems that fall within its sphere of competence.

The "poor farm," the "alms house," the "pest house," the "relief home," with the adjacent potter's field, were all too familiar landmarks in the communities of yesterday. These institutions, with their tragic complement of dehumanized and depersonalized "inmates" reflected with shocking clarity the discrepancy between the humanity which we professed and the inhumanity which we practiced. The practices of that bygone period were directly derived from certain concepts of human value. In the behavioral field, it was generally accepted that dependency and/or disordered behavior were indices of basic, inherent depravity not amenable to treatment or amelioration. Banishment of these unworthy members of society into institutions which, though sometimes camouflaged by euphemistic designation, were basically punitive in nature, was the accepted and approved choice.

A second group of citizens who found themselves recipients of the same community banishment and often into the same institutions were the severely disabled, the chronically ill, and the infirm older persons, who were found to be "deficient in economic resources" or to put it more starkly, "poor." In the case of the elderly, it was accepted that infirmity, debility, mental deterioration and incapacity were the inevitable consequences of the aging process, superimposed upon an inferior, inadequate and basically unworthy individual.

San Mateo County, in common with many other enlightened communities, has participated in critical self evaluation of some of these old concepts and beliefs and as a result has developed or accepted new concepts and new philosophies with respect to improved treatment services in the health, welfare and correctional field. Since space will not permit a report of the full sweep of change and improvement in all treatment services stemming from these new concepts, this presentation will be limited to the one dramatic example indicated by the title.

Rehabilitation Begins

"Until February 1954, the Crystal Springs Home, a 135 bed county institution, had been operated as a 'relief home,' with the 'inmates' receiving 'custodial care for elderly indigents.' Adrian Ward, superintendent of the social service division at that time, recommended as the new manager, Einor Nordby, a man with broad experience in social work. Mr. Nordby brought to his new job more than good training and broad experience; he brought two other characteristics of inestimable value: a strong conviction about the values of rehabilitation and an abiding faith in the infinite capacity of human beings to overcome seemingly insuperable handicaps and, I might add, a sincere respect for human dignity. Within a few weeks, the 'relief home' had become the 'Crystal Springs Rehabilitation Center,' the 'inmates,' 'patients,' and 'custodial care for elderly indigents' became 'rehabilitation treatment services for patients with long-term illness.'"[1] There was not then, and there is not now any specific age limit. The range has been from 14 to 99 years.

While it did not take long to change names and terms, it took a little longer to develop the program and philosophy indicated by these terms and to teach a largely untrained staff to center their efforts on restoring dignity, status, self-respect, and self-esteem in the individual patient. The dietary was improved after a survey by the nutrition section of the State Health Department. Little things were initiated, such as arranging the mealtime to more nearly coincide with normal mealtime hours, placing sugar and condiments on the table to afford patients free choice of seasoning, providing a before-bedtime snack, consulting patients on their likes and dislikes, and serving food as attractively as possible instead of inmate style. None of these things alone had too much significance, but indicated to the patients that the management considered them humans capable of personal decisions with opinions of value in determining policy.

[1] Public Health Reports, Vol. 73, No. 1, January 1958, pp. 42-46.

A second method of providing motivation to the patients was to form committees to discuss policy and program—a library committee, an occupational therapy committee, and a patients' service committee. Budgetary limitations did not permit the employment of additional staff the first year of operation, so the manager and the committees turned to the community for volunteer help. The relief home had been shunned by the community, except for a few stalwart church groups and people who "wanted to do something for the poor" during the holidays. But with the new spirit, which is hard to describe but was immediately felt, community organizations, service clubs, church groups, women's clubs, and others became enthusiastic sponsors of various rehabilitation activities, providing materials, tools, and money, and finding qualified volunteer arts and crafts teachers. The patients exhibited their handiwork at the annual fiesta (county fair); they organized an annual bazaar, and started a monthly newspaper.

These activities gave status and helped restore sadly depleted self-esteem. The "inmates" were again human beings with personalities and skills. These activities gave new hope and incentive, but this was not enough. The physically disabled were still disabled, though their outlook had improved. The mildly depressed responded well, but the severely depressed were still depressed. Again volunteers were recruited—a psychiatrist, a part-time physical therapist, an occupational therapist, and social workers in the evenings after their regular day's work.

Professional Staff

Time and space do not permit a step by step development of the program from 1954 to 1960. The demonstrated accomplishments have convinced the Board of Supervisors and the community that rehabilitation treatment rather than custodial care is the modality of choice. This conviction is evidenced by the steady increase in the number and kind of professional disciplines added to the rehabilitation team. As of May 1960, the professional staff consisted of the following members:

Internist—3 (part-time)
Physiatrist—1 (part-time)
Psychiatrist—1 (part-time)
Urologist—1 (part-time)
Orthopedic Consultant—1 (part-time)
Physical Therapist—2 (full-time)
Occupational Therapist—2 (full-time)
Medical Social Worker—1 (full-time)
Dietitian—1 (full-time)
Speech Therapist—1 (full-time)
Vocational Counselor—1 (part-time)
Director of Rehabilitation Nursing (M.S. degree)—1
Charge Nurses (R.N.)—10

The members of this team meet in case conferences to staff all new admissions and do discharge planning. The patient may participate in both the original rehabilitation program planning and the discharge planning phase where it is felt by the team that this would be helpful. In general, the physicians approach the medical problems presented by the patient as being the consequence of specific identifiable diseases which can be treated, arrested, retarded or ameliorated through intensive coordinated and effective use of medical, social, emotional, and vocational therapies. This attitude is fully shared by all members of the team, and this positive, optimistic, hopeful outlook permeates throughout the institution with the resultant therapeutic benefit that both patients and staff respond in positive ways that enhance the prospect for restoration and recovery on the part of each individual patient.

Sound Investment

It is true that the addition of these professional positions has increased the per patient day cost. It is significant, however, that in the judgment of the board of supervisors these added costs are regarded more as an investment in enhancing human well-being rather than merely an expense item per se. As a happy corollary, this additional expenditure has proven to be a sound public investment. While the following brief summary of admissions and discharges does not tell the full story, it is indicative of the fact that a substantial number of citizens have been restored to various degrees of independent living in their own communities as a result of this new approach in institutional care.

PATIENT FLOW FROM JANUARY 1, 1954 TO JANUARY 1, 1960

Admissions	569
Deaths	69
Total	500
Discharges to	
Employment	68
Private living	244
County hospital	140 *
Other institutions	48 †

* To Community Hospital (County general hospital) for more intensive medical care.
† To County Tuberculosis Sanatorium (chronic disease ward), Agnews State Hospital, Soldiers Home (Yountville), and private nursing homes.

The above table represents the unduplicated count. There have been additional discharges and readmissions within the period between Crystal Springs Rehabilitation Center and Community Hospital. In the main, these have been part of the medical rehabilitation program where corrective surgical procedures, extensive diagnostic work-up, or acute illnesses can be more effectively handled in a general hospital. This type of discharge does not represent final disposition since it was in the plan that the patient would return to the Rehabilitation Center for continued therapy upon completion of care in Community Hospital.

Of the 140 discharges to Community Hospital, with no subsequent readmissions, it is known that many were terminally ill and expired shortly afterward. In other instances it was the judgment of the Evaluation Team at Community Hospital and the Rehabilitation Team at Crystal Springs Rehabilitation Center that the patient would not respond to further rehabilitation treatment procedures and that only bedside nursing care was indicated. In these cases the patient was transferred to one of several private nursing homes which provide this type of care.

This brief statistical summary is not sufficiently definitive to warrant any general conclusions being drawn and is not presented in that view.

Dollar Savings

The direct dollar savings to the county that might be calculated from the 312 patients returned to employment or private living would reach substantial figures.

As a tentative projection, and for purposes of comparison only, it might be fairly safely estimated that the cost of maintaining the 312 patients in nursing homes in this community

would average $300 per month or $3,600 per year.

$3,600 × 312 = $1,123,200 per annum

Assuming that the 68 discharged to employment are self-sufficient and that the 244 living in private residential quarters do so at a cost of $150 per month (which is somewhat above actual budgetary computations) or $1,800 per year, then a resultant saving to the community might be projected as follows:

$1,800 × 244 = $439,200

Medical Institutional Care Costs	$1,123,200 per year
Private Living Costs	439,200 per year
Savings	$684,000 per year

It is not the intent to minimize the significance of the financial aspect since the high costs of long-term institutionalization are well known. In fact, many studies projecting the ultimate cost of caring for the continuously increasing proportion of people in the older age bracket indicate that this will be an insupportable burden for the remaining working population unless immediate, positive, constructive measures are taken to restore this group of people to the highest possible level of independent self care. It is a great satisfaction to know that, at the same time that these desirable economic objectives are being achieved, the community gains also from the contributions that can be made by this group of people who have this second chance for self-fulfillment and realization of the goals of active productive participation in the good life envisioned by our society.

Expanded Construction

As further evidence of the concern of this community in providing the best treatment services feasible for its disabled or chronically ill citizens, construction was started in May 1960 of a new addition to the facility which will provide one of the finest integrated comprehensive treatment centers in the area as well as adding 65 additional patient beds. This expansion was made possible through county, state and federal cooperation under the Hill-Burton Act, which made funds available for the development or expansion of comprehensive rehabilitation treatment centers.

While the enlightened attitudes of this community made possible the beginnings of this service, the actual participation in the rehabilitation program by organizations and individual volunteers has strengthened the program itself and added substance to the community's concept of its responsible role in this effort.

Internal Organization

Insofar as the facilities permit, the patient areas have for several years been divided into intensive care, intermediate care, and self care. It has been found that many advantages accrue from this, both in terms of staffing and in terms of progressive patient movement. The concentration of services during the initial period while the patient is on the intensive care ward not only insures the best of medical direction and treatment but also gives to the patient the kind of emotional reassurance that helps to relieve the oftentimes severe anxiety found upon his arrival. In addition to the medical treatment prescribed by the internists, the physical therapists and occupational therapists under the direction of the physiatrist do a complete inventory of the patient's capabilities for self care at the time of arrival. The patient is periodically re-evaluated and, when it is felt by the team members directly concerned that that patient is ready for transfer from the intensive care ward into intermediate or self care areas, he is then prepared for this new experience. This may include discussions with the physician, the social worker, the nursing supervisor, as well as others who may have established close personal relationships with the patient. It should be mentioned that while the patient is on the intensive care ward he has been actively involved in physical therapy and occupational therapy and has been through a training program in the activities of daily living. It has been found from a psychological standpoint that the progressive movement from intensive, to intermediate, to self care, has been helpful in building up the patient's confidence in his ability to handle his own problems and to meet his own needs. Because he has actually performed these activities over an adequate period of time under medical and paramedical observation, he knows, and the rehabilitation team knows, that when a suitable living arrangement can be worked out for him in his home community, he will in all likelihood make a successful return to independent living. As a final reassurance to those patients who may still be somewhat fearful, it has been a practice of the institution to advise the patient that if things go wrong, the institution will do everyhing possible to be helpful to him. It is interesting to note that there have been relatively few instances where the institution has been called upon to intervene under this agreement. It has seemed that the very knowledge that the whole team was behind him, and that he was not alone, has been a factor in giving him the confidence to deal with the many minor problems and irritations that are bound to arise in the lives of all people. It is felt that this is an essential part of the services and that great flexibility must be maintained in the operations of the community rehabilitation treatment center so that it can respond more adequately and more effectively in providing constructive help in meeting community needs. It must ever be borne in mind that the rehabilitation center is not separate and isolated but is an intimate, closely related, integral part of community life. While in its internal operations it functions in many ways as a neighborhood or a small community would, and this aspect of it is extremely important, yet it must not be forgotten that the purpose is to return the pa-

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tient to his own real neighborhood or community with maximum capacity for effectively functioning on his own with minimum dependency upon the institution. To describe this aspect of the treatment services would require more space than is possible in this limited presentation.

Conclusion

In summary and in retrospect, it might be said that while attitudes influence community behavior, behavior also influences attitudes. The very fact that the community established the Crystal Springs Rehabilitation Center to provide comprehensive services in place of minimal custodial care, a concrete demonstration within, and of, and by the community itself, has been a factor in making it possible for the community to rise above some of its earlier prejudices against those of its members who suffered physical or emotional disabilities accompanied by financial distress. Perhaps we may discern a greater readiness to accept the concept that people have inherent, enduring values aside from the symbols commonly associated with success. If the conversion from "relief home" to "rehabilitation center" has been helpful in giving meaning to such concepts, then, in addition to the direct benefits to the patients involved, and to the financial operations of the tax-paying community, there has been added this extra and perhaps far more significant dividend in terms of a more enlightened approach to the problems of people.

Perhaps we can see emerging the community of the future which will have as one of its major concerns the health and well being of all its members.

Health Services for Adolescents

Interest in medical services for young adults is growing in California. Some physicians are setting aside special blocks of time for teenagers, and are adapting office procedure to meet the needs of this specific age group.

One of the first clinics in the State of California designed specifically for young adults or teenagers was established at the Oakland Kaiser Foundation Medical Center in 1953 by Dr. Arthur Roth. This proved to be a popular medical service, and increasing utilization by young people has resulted in an expanded service. Young people come to the clinic for routine medical examinations and also many come because of acute or chronic illnesses.

This clinic now has separate physical facilities with two full-time and three part-time physicians, and a total case load of 600 patients per month.

Other clinics for this age group have been started in this state: the Youth Clinic at San Francisco's Children's Hospital and Teenage Clinics at the Kaiser Foundation Hospitals at San Francisco, Richmond, and Los Angeles as well as the High School Clinic at the Eastbay Children's Hospital and the new Adolescent Service of the Berkeley Pediatric Group. California's medical schools are approaching the teaching of adolescent health care in various ways. Stanford University School of Medicine plans to have a separate teenage outpatient facility as well as an education program for this new "specialty" in medicine.

"One out of every 12 Americans will be hospitalized for mental illness at some time in his life. Half the hospital beds in the country are used for the treatment of such illness."—*George Bugbee, Health Information Foundation.*

"The rate of persons resident in mental hospitals has declined significantly, from 389.5 per 100,000 population in 1954 to 360.7 per 100,000 in 1958. Today's increasingly effective treatment of mental disorders by a variety of methods, including new drugs, enables many patients to avoid long periods of hospitalization."—*George Bugbee, President, Health Information Foundation.*

Department Exhibit Receives Certificate of Merit

The California State Department of Public Health exhibit on alcoholic rehabilitation received one of ten certificates of merit presented to outstanding scientific exhibits by the Exhibit Evaluation Committee of the American Public Health Association at the Annual Meeting held in San Francisco in November. Eighty-four scientific and 85 technical exhibits were displayed at the convention.

The Department's alcoholic rehabilitation exhibit is available on a limited basis for loan to professional organizations throughout the State which are interested in the problem of alcoholism.

Infectious Hepatitis—Epidemiologic Note

Infectious hepatitis is on the increase in California and in the United States. The Public Health Service reports that the incidence of hepatitis in the United States was 44.7 percent higher in 1959 than in the previous year. The report states that the disease appears to be occurring in cycles, the past peak being in 1954. The low point of the cycle was in 1957, followed by an increase of reported cases in 1958 and again in 1959. The increase has continued into 1960.

In California, the same pattern is observed. The table is a summary of the cases by area for 1954-1959 and through September of 1960. As noted from this table more cases were reported in 1959 than in any previous year in California. During the first nine months of 1960 approximately 800 more cases have been recorded than for the entire year of 1959.

Cases are spread throughout the State. Certain areas have recorded an increasing number of cases each year, e.g., Los Angeles metropolitan area. Considerable fluctuation is observed within some areas, for example, the Sacramento Valley. The highs and lows vary in different areas from year to year.

There does not appear to be a definite seasonal occurrence for infectious hepatitis. The disease occurs at any time of the year.

Fluctuations in individual counties are due to localized epidemics in some instances. This was true in Alameda County where two outbreaks occurred in housing projects. Also in Tulare County a number of cases were reported from an Indian Reservation. These are isolated incidents, however, and do not entirely explain the marked overall increase in reported cases.

There are questions which arise from observations of these data. Are we approaching a new endemic level, similar to 1954? Is the increase real, or is it a reflection of better diagnosis and better reporting? What are the clinical signs and symptoms of the cases being reported? Are more cases without jaundice being recognized than previously? Are common source outbreaks occurring? What is the proportion of multiple and single cases?

The answers to the above questions must come from the local level. Although epidemiologic case histories are no longer requested by the State Department of Public Health, local health departments can collect and analyze case histories and report the general situation within their jurisdictions. Such reports help to interpret the sharp increase in cases and indicate if and where special localized studies should be carried out.

DISTRIBUTION OF REPORTED INFECTIOUS HEPATITIS CASES IN CALIFORNIA BY GEOGRAPHIC AREA
1954-1960 *

Area	Year						
	1954†	1955	1956	1957	1958	1959	1960
California (Total)	2,285	1,918	2,015	1,796	1,986	2,621	3,412
1. North Coast	87	110	50	68	42	49	54
2. Sacramento Valley	263	121	141	39	53	79	97
3. Mountain	93	89	51	29	155	63	104
4. San Francisco Bay	365	227	278	286	344	392	698
5. Central Coast	55	50	43	21	20	47	109
6. San Joaquin Valley	423	288	149	133	157	364	450
7. South Central Coast	164	50	10	39	82	68	77
8. Los Angeles Metropolitan	653	844	993	901	840	1,231	1,506
9. San Diego	119	73	64	116	126	179	151
10. Southwest	55	56	50	66	114	142	160
Out of State	6	10	16	14	19	7	6
Institutions	--	--	170	84	--	--	--
Military	--	--	--	--	34	--	--

* Jan.-Dec. 1954-1959; Jan.-Sept. 1960.
† Serum Hepatitis included.

SOURCE: State of California, Department of Public Health, Bureau of Acute Communicable Diseases.

New Insecticide for Mosquito Control

An important advancement in California's mosquito control technology appears in prospect with the recent announcement by the State Department of Public Health that an outstanding new insecticide is now available.

This material, an organophosphorous compound, has the chemical name of 0, 0-dimethyl 0 [4-methylthio)-*m*-tolyl] phosphorothioate. The first samples for testing purposes were obtained by the Bureau of Vector Control research unit from the laboratory in West Germany where the basic compound was discovered.

Early in the 1959 testing season at the Bureau of Vector Control toxicology laboratory near Fresno, research entomologists became impressed with the extraordinary potential of the new material, both in laboratory and field tests. New compounds, in rapid succession, are being tested against standard laboratory strains of mosquitoes at the Department's vector research unit. Only a few of these materials, however, show sufficient promise to warrant their being subjected to intensive field tests. The new insecticide in field applications as low as 0.025 lb./acre produced virtually complete kill of the late aquatic stages of *Culex tarsalis,* the mosquito which transmits encephalitis, and *Aedes nigromaculis,* California's principal pest mosquito. It has the additional advantage of being less toxic to warm-blooded animals than chemicals currently used in mosquito control.

Following federal and state registration and approval, some 2000 gallons of this new compound, in a 4 lb./gallon formulation, was made available this year by the German manufacturers for use in the California program. It is anticipated that the material will be manufactured in this country within the next year.

The most striking trend in the mental hospital field—the actual decline in resident patients between 1955 and the present, both in number and rate, especially in public mental hospitals—apparently does not result from any decline in admissions since 1955. Rather it stems from an apparent speeding up in discharges.—*Progress in Health Services, Health Information Foundation,* October 1960.

California Births Increase, Reversing National Trend

The number of births in California so far this year is steadily rising, the reverse of the national trend which shows a decline in the number of births.

If the rise in California continues through the remainder of the year, it is predicted that 372,000 babies will be born, some 14,000 more than recorded in 1959. The birth rate, however, will be 23.5 per thousand, the same as last year.

The National Office of Vital Statistics has reported a current decline in the total number of babies born in the Nation for the first half of 1960. The increase in California may be due to a slightly younger age distribution of the population than in the United States as a whole.

The death rate in California is expected to increase slightly in 1960, reflecting largely the relatively high level of mortality resulting from the pneumonia and influenza outbreak during January and February.

Barring any unusual increases in the last quarter, California will have approximately 136,000 deaths this year, and the crude death rate will be 8.6 per thousand, about two percent higher than 1959.

The total population increase in California for 1960 is expected to be about 570,000. The increment due to natural increase will be about 236,000, or 41 percent of the total increase.

Natural increase is steadily becoming a more important factor in California's population growth. So far in the State's history, migration has played the major role in the expanding population. From 1900-1950, less than two million persons were added to California's population through natural increase, while seven million were added by net migration.

New Assistant Chief for Division of Research

Louis F. Saylor, M.D., M.P.H., has been appointed Assistant Chief, Division of Research, California State Department of Public Health, effective November 1, 1960. Dr. Saylor joined the Department staff after 22 years with the United States Army, his most recent position being that of Deputy Surgeon and Chief of the Preventive Medical Division of the Sixth Army.

Dr. Saylor received his M.D. degree from the University of Nebraska in 1937 and his M.P.H. from Harvard University in 1957. He will be responsible for the planning, organization, and direction of the disease surveillance and health measurement program of the Division of Research, of which Dr. Robert Dyar is Chief.

Prenatal Care Standards Adopted by Department

The California State Department of Public Health has published in booklet form the standards and recommendations for public prenatal care which were adopted by the Department in July.

The standards were developed as the outgrowth of a 1955-56 study which showed serious deficiencies in quality and quantity of prenatal care available at that time. Then, as well as now, maternal and neonatal mortality was higher in county hospitals than in other hospitals.

The Department's Advisory Committee on Maternal and Child Health urged that standards be developed as a means of improving the care given in public institutions, thereby reducing the mortality rate.

While these standards and recommendations are offered as a guide to professional health workers responsible for providing public prenatal care services, they may also be helpful to physicians in private practice and to staff of non-tax-supported prenatal care facilities.

The standards and recommendations were reviewed by the Committee on Health Services, California Conference of Local Health Officers; the Committee on Maternal and Child Care, California Medical Association; and the Council of County Hospitals, California Hospital Association. They were finally recommended to the State Department of Public Health for adoption by the State Advisory Committee on Maternal and Child Health.

Assistance in their preparation was given by physicians, nurses, nutritionists and dietitians, hospital administrators, social workers, and health educators.

Notice

The name of the Bureau of Acute Communicable Diseases in the California State Department of Public Health has been changed to the Bureau of Communicable Diseases. It is felt that the word "acute" is no longer descriptive of the work being done in the bureau, which is now responsible for control of venereal diseases and tuberculosis, diseases which often tend to be chronic.

Public Health Positions

Contra Costa County

Clinical Laboratory Technologists: Salary range, $436 to $530. No written test required. Minimum standards include possession of a valid license as a clinical laboratory technologist in California.

Health Educator: Salary range, $530 to $644. Written examinations will be administered to candidates in locations convenient to them. Minimum standards include possession of the degree of master of public health in the field of public health education.

Sanitarian: Salary range, $481 to $584. Promotion to senior sanitarian, salary $530-$644, is possible with two years experience as a sanitarian after one full year with the Contra Costa County Health Department. Written tests will be administered in locations convenient to candidates. Minimum standards include possession of a Certificate of Registration as a sanitarian in California.

Liberal employee benefits for health department employees include three weeks vacation, twelve days sick leave each year, two group health plans, county retirement plan, plus Social Security benefits. Information and applications may be obtained by writing to Contra Costa County Civil Service Department, Room 229, Hall of Records, Martinez, California. Phone: AC ademy 8-3000, Ext. 415.

Humboldt-Del Norte County

Director of Public Health Nursing: Salary range $519-$649. Starting level negotiable and automatic step increase after first six months. Generalized program in semi-rural bi-county jurisdiction in Redwood Empire on Pacific coast serving population of 125,000. California PHN certification and administrative experience required. Nursing staff of 15 including supervisor. Work week is 37½ hours. Apply to L. S. McLean, M.D., Health Officer, Humboldt-Del Norte County Health Department, 805 Sixth Street, Eureka, California.

Public Health Nurse: Salary range $439-$549. Advance to second step after six months. Generalized program, including school nursing. Requires California PHN certificate. County car furnished. Apply to L. S. McLean, M.D., Health Officer, Humboldt-Del Norte County Health Department, 805 Sixth Street, Eureka, California.

Los Angeles City

District Health Officer: Salary range, $992-$1236. Must be duly licensed to practice medicine in the State of California and have had one year public health medical experience in a public health agency. Master's degree in public health desirable. Write to: George M. Uhl, M.D., Health Officer, Los Angeles City Health Department, 111 East First Street, Los Angeles 12, California.

San Mateo County

Public Health Analyst and Registrar: Salary range, $491-$614. To work in combined public health and welfare department. Requires college degree supplemented by course in statistics and one year of research or statistical experience in public health and welfare.

Supervising Public Health Nurse: Salary range, $505-$632. Requires college graduation, one year post-graduate study in nursing, and three years supervisory public health nursing experience.

Apply to Civil Service Commission, Court House, Redwood City.

Yolo County

Sanitarian: Salary range: $373 to $455; may start at second step depending on experience. Generalized sanitation program; newly constructed health department serving a population of 65,000. Apply to Herbert Bauer, M.D., Public Health Director, Yolo County Health Department, Woodland, California.

REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF OCTOBER, 1960

Disease	*Cases reported this month*			*Total cases reported to date*		
Series A: By Place of Report	*1960*	*1959*	*1958*	*1960*	*1959*	*1958*
Amebiasis	29	39	52	387	526	915
Coccidioidomycosis	40	47	27	212	241	175
Measles	274	494	687	21,465	39,751	33,963
Meningococcal infections	12	9	15	169	168	163
Mumps	1,377	943	792	20,800	10,883	15,211
Pertussis	188	170	349	1,655	2,153	3,442
Rheumatic fever	8	9	8	122	122	117
Salmonellosis	120	102	125	1,067	976	888
Shigellosis	224	228	293	1,740	1,735	1,584
Streptococcal infections, respiratory	2,150	2,738	1,668	25,494	19,477	11,845
Trachoma	2	--	4	93	23	6
Series B: By Place of Residence						
Chancroid	5	10	9	98	67	77
Conjunctivitis, acute newborn	--	2	4	12	7	18
Gonococcal infections	1,727	1,340	1,856	15,731	14,138	14,606
Granuloma inguinale	--	1	--	10	2	8
Lymphogranuloma venereum	--	--	4	24	15	28
Syphilis, total	635	465	584	6,531	5,671	5,184
Primary and secondary	128	68	88	1,294	870	506
Series C: By Place of Contraction						
Botulism	--	--	--	--	2	1
Brucellosis	1	3	4	17	13	32
Diarrhea of the newborn	--	1	2	6	55	19
Diphtheria	--	1	1	--	6	6
Encephalitis	31	53	55	450	356	500
Food poisoning (exclude botulism)	167	77	99	1,421	1,345	941
Hepatitis, infectious	463	218	189	3,875	2,154	1,657
Hepatitis, serum	11	13	8	108	79	97
Leprosy	--	1	2	7	15	12
Leptospirosis	1	--	--	2	3	2
Malaria	--	1	6	11	24	21
Meningitis, viral or aseptic	69	79	206	608	747	800
Plague	--	--	--	--	2	--
Poliomyelitis, total	37	69	67	391	392	259
Paralytic	35	60	60	344	333	190
Nonparalytic	2	9	7	47	59	69
Psittacosis	2	--	1	13	14	16
Q fever	--	6	3	30	59	35
Rabies, animal	5	12	7	102	112	146
Rabies, human	--	--	--	--	1	--
Relapsing fever (tick borne)	--	--	--	6	3	--
Rocky Mountain spotted fever	--	--	--	2	3	--
Tetanus	2	6	3	28	38	39
Trichinosis	--	2	1	3	7	5
Tularemia	--	--	1	3	4	4
Typhoid fever	11	9	19	53	67	61
Typhus fever (endemic)	--	--	--	--	3	3
Other *						
Tuberculosis [1]				4,285	4,388	4,988

* This space will be used for any of the following rare diseases if reported: Anthrax, cholera, dengue, relapsing fever (louse borne), smallpox, typhus fever (epidemic), yellow fever.

[1] Tuberculosis cases are corrected to exclude out of state residents and changes in diagnosis; monthly figures are not published.

Personals

Malcolm H. Merrill, M.D., California State Director of Public Health, was elected Vice-President of the Association of State and Territorial Health Officers at their annual meeting in San Francisco in October. As Vice-President, Dr. Merrill becomes a member of the Executive Committee of the association. He previously served for three years on that committee.

Attorney General Opinion

Pesticide chemicals, which manifest themselves in meat or milk because the livestock have fed on hay or fodder sprayed by such chemicals, have been added to the meat or milk and therefore are "spray residue" within the scope of Agricultural Code section 1010(a), according to Opinion No. 60-89 of the Attorney General.

In analyzing the problem, the Attorney General states that, "Protection of the quality and quantity of agricultural crops by the use of pesticide chemicals is necessary to assure an adequate supply of high-grade food. However, when livestock consume hay or fodder sprayed by such chemicals, a residue of harmful substances may occur which could endanger consumers of milk, meat, or their by-products."

To alleviate this problem, the Spray Residue Article of the Agricultural Code (sections 1010 through 1014) authorizes the Director of Agriculture to "establish permissible tolerances for any pesticide chemical in or on produce."

The opinion goes on to define "spray residue", "pesticide chemical", "produce" and "food", and also enumerates certain commodities which are "produce" within the purview of section 1010(c) of the Agricultural Code.

The Agricultural Code is not the only means by which the consumer is protected from harmful substances in food. The Attorney General points out that California's Pure Food Act sets forth circumstances in which food is deemed to be adulterated, and prohibits the "manufacture, production, preparation, compounding, packing, selling, offering for sale or keeping for sale" of food which is adulterated.

San Francisco Draws 4,800 To 88th Annual APHA Meeting

More than 4,800 public health workers from the United States and various other countries attended the 88th Annual Meeting of the American Public Health Association in San Francisco, October 31 through November 4. This is the first time the APHA has met in the West since 1951, when the meeting was also held in San Francisco.

New Officers

As President-Elect, Marion W. Sheahan, R.N., Deputy General Director, National League for Nursing, New York City, succeeded Malcolm H. Merrill, M.D., California State Director of Public Health, to the presidency of the association for 1961. Charles Glen King, Ph.D., Executive Director, National Nutrition Foundation, New York City, became the new President-Elect. The Vice-President elected from Canada is G. R. F. Eliot, M.D., Vancouver, B.C.; the Vice-President from the United States is Margaret F. Shackelford, Oklahoma City; and the Vice-President from Latin America is Humberto Olivero, Jr., Guatemala City. D. John Lauer, M.D., New York City, is the new treasurer.

Dr. Merrill, the outgoing president, presided at both general sessions of this year's meeting.

Awards

At the first general session, Fred T. Foard, M.D., was presented with the Sedgwick Memorial Medal for distinguished service in public health. Dr. Foard is Director, Division of Epidemiology, North Carolina State Board of Health, Raleigh, N.C., and was formerly Director of Health and Medical Services, Indian Affairs Bureau, Department of the Interior, Washington, D.C. The Sedgwick Memorial is the first and oldest of the awards presented in recognition of distinguished public health contributions.

Adlai Stevenson and Governor Edmund G. Brown were featured speakers at the second general session, at which the Lasker Awards were presented. Details of this year's Lasker Award selections were given in the November 15 issue of *California's Health.*

Section Officers

A number of Californians were elected to offices in the various sections of the APHA. They are: *Epidemiology Section,* Arthur C. Hollister, M.D., Chief of Administrative Research, Division of Research, California State Department of Public Health, Secretary; *Food and Nutrition Section,* Emil M. Mrak, Chancellor of the University of California at Davis, Vice-Chairman; *Health Officers Section,* Ellis Sox, M.D., San Francisco City-County Health Officer, Chairman, and Harold M. Erickson, M.D., Deputy Director, California State Department of Public Health, Member of the Council; *Laboratory Section,* Floyd W. Hartmann, Sc.D., Assistant Chief, Division of Laboratories, California State Department of Public Health, Member of Association Standing Committee on Eligibility; *Mental Health Section,* Joseph J. Downing, M.D., Program Chief, Mental Health Service, San Mateo County Department of Public Health and Welfare, Secretary; *Occupational Health Section,* Fred R. Ingram, Private Industrial Hygiene Engineering Consultant, Berkeley, Chairman; *Public Health Nursing Section,* Eva M. Reese, Director of Public Health Nursing, San Mateo County Department of Public Health and Welfare, Secretary-Elect.

The next annual meeting of the association will be held in Detroit, November 13-17, 1961.

Interpol's number one crime problem is dope. And the United States is the number one center for the sale of illegal narcotics. More money is spent here for dope than anywhere else in the world.—*Science News Letter,* October 22, 1960.

Somewhere along the path of evolution between rabbits and man, a particular liver enzyme disappeared. Loss of this liver enzyme is the reason man is unable to manufacture vitamin C within his own body, a team of researchers from India has reported.—*Science News Letter,* October 22, 1960.

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